

<b>Case Number:</b>	CM14-0142271		
<b>Date Assigned:</b>	09/10/2014	<b>Date of Injury:</b>	04/28/2013
<b>Decision Date:</b>	01/07/2015	<b>UR Denial Date:</b>	08/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/02/2014

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in Minnesota. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 65 year old female who fell on 4/28/2013 injuring the left wrist, ankle, knee, and shoulder. She underwent knee surgery for a torn meniscus on 10/16/2013. MRI scan of the left shoulder dated 4/15/2014 revealed a full thickness vs near complete tear of the supraspinatus tendon with retraction and partial thickness tear of the infraspinatus with moderate to severe infraspinatus tendinitis, subscapularis tendinitis, and moderate subacromial and subdeltoid bursitis. The labrum was intact. Minimal acromioclavicular arthritis was noted. An MR Arthrogram of 6/9/2014 revealed full thickness tear of the supraspinatus extending to the anterior fibers of the infraspinatus on a background of tendinosis. No labral tear was noted. Range of motion of the left shoulder on 3/28/2014 was flexion 170 degrees, abduction 90 degrees, internal rotation 18 degrees and external rotation 70 degrees. On 6/27/2014 the flexion was 90 degrees, abduction 90 degrees, internal rotation 19 degrees, and external rotation 90 degrees. A request for left shoulder arthroscopy versus open rotator cuff repair, and ancillary services was non-certified by UR for lack of documentation of subjective functional status since the injury date and lack of detailed evidence of failed conservative treatment.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**Left Shoulder Arthroscopy versus Open Rotator Cuff Repair: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints  
Page(s): 209, 210, 211, 213, 214.

**Decision rationale:** California MTUS guidelines indicate surgical considerations in the presence of red-flag conditions such as an acute rotator cuff tear in a young worker. Surgery is indicated if there is activity limitation for more than 4 months or failure to increase the range of motion and strength despite a supervised exercise program and clear clinical and imaging evidence of a lesion that is known to benefit from surgery. Documentation of conservative treatment with exercises and injections of corticosteroids is necessary. Rotator cuff repair is indicated after rehabilitation efforts have failed per guidelines. The documentation submitted does not indicate a failed program of conservative treatment and as such, the request for left shoulder arthroscopic versus open rotator cuff repair is not supported by guidelines and is not medically necessary.

**Post Op Physical Theray x 20 visits:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Post Op CPM:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Hot and Cold Unit:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.